Lions Eye Institute

FOR TRANSPLANT & RESEARCH

Leading Locally. Reaching Globally.

Surgeon Registration

1

Contact Information:

Surgeon Name_______________

Surgeon Email_______________ Surgeon DOB*___________

OK to Contact Surgeon: ☐ After Hours ☐ On Weekends ☐ By Text Cell_____/_______________

Average Transplants Performed Monthly_______ Surgery Days ☐ M ☐ T ☐ W ☐ Th ☐ F

Practice Name_______________

Address_______________

City_______________ State_________ Zip___________

Surgical Coordinator *(requests tissue & receives tissue offers)*_______________

Preferred Method of Contact: ☐ Email ☐ Phone ☐ Cell ☐ Fax Phone_____/___________

Email_______________ Cell_____/___________ Fax_____/___________

**DOB is required when registering*

Surgical Facility No. 1:

Surgical Facility Name_______________

Delivery Address_______________

City_______________ State_________ Zip___________

Phone_____/___________Ext_______ Fax_____/_______________

Contact Name_______________ Email:_______________

Cell_____/_______________ PO Required? ☐ Yes ☐ No Delivery Hours_________—_________

Billing Address *(if different than Delivery)*_______________

City_______________ State_________ Zip___________

Surgical Facility No. 2:

Surgical Facility Name_______________

Delivery Address_______________

City_______________ State_________ Zip___________

Phone_____/___________Ext_______ Fax_____/_______________

Contact Name_______________ Email:_______________

Cell:_____/_______________ PO Required? ☐ Yes ☐ No Delivery Hours_________—_________

Billing Address *(if different than Delivery)*_______________

City_______________ State_________ Zip___________

Space for additional surgical facilities on page 3.

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Tissue Offer Preferences:

Maximum Death to Preservation Time *(in hours)*_________ Maximum Death to Surgery Time *(in days)*___________

Exclusionary Criteria *(if any)*____

	PKP	DSAEK / UT DSAEK	DMEK
Minimum Cell Density:	____________	____________	____________
Minimum Donor Age:	____________	____________	____________
Maximum Donor Age:	____________	____________	____________

Other Types of Surgeries Performed ____

Tissue Processing Preferences:

Preferences will be added to your profile and referenced when processing is requested. When custom preferences are necessary for a patient, simply indicate specifics on the tissue request form.

DSAEK

Thickness Range
☐ Ultrathin 40-70 μm ☐ Ultrathin 71-99 μm ☐ Traditional 100+ μm

Target Thickness_________ Processing capabilities are ± 25 μm of requested target.

Preloaded: ☐ Yes ☐ No Prestained: ☐ Yes ☐ No

If PRELOADED, choose preferred preloaded device and graft size:
☐ Weiss Glass Cannula – LEITR 2.8 ☐ DSAEK Endoglide

Graft size *(in mm)*:
☐ 7.00 ☐ 7.25 ☐ 7.50 ☐ 7.75 ☐ 8.00 ☐ 8.25 ☐ 8.50 ☐ 8.75

DSAEK Orientation Marking Options:
Please choose one or a combination of markings.

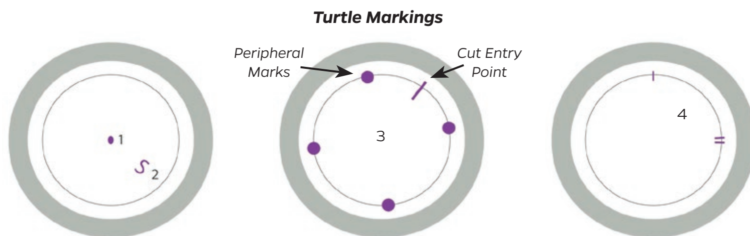
☐ **1.** central dot on cap for cornea centration

☐ **2.** "S" mark on stromal side of the graft

☐ **3.** Turtle Markings

☐ **4.** I - II marks (preloaded only)

☐ **5.** No Markings



DMEK

Prestained: ☐ Yes ☐ No

Prepunched: ☐ Yes ☐ No

Preloaded: ☐ Yes ☐ No

If preloaded, choose preferred device below:

☐ Preloaded in Weiss Glass Cannula – LEITR 1.6

☐ Preloaded in Weiss Glass Cannula – STRAIKO

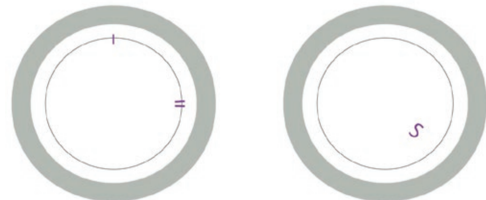
☐ Preloaded in DMEK EndoGlide

If prepunched or preloaded, include graft size (in mm):

☐ 7.00 ☐ 7.25 ☐ 7.50 ☐ 7.75 ☐ 8.00 ☐ 8.25 ☐ 8.50 ☐ 8.75

DMEK Orientation Marking Options:

☐ I - II (Anterior View) Prepunched, preloaded option only ☐ "S" Stamp (Anterior View)



Please save before sending completed forms to cornea@lionseyeinstitute.org or fax to 813.289.3600.

1410 N 21st Street, Tampa, FL 33605-5313 | 813.289.1200 | f 813.289.3600 | lionseyeinstitute.org | cornea@lionseyeinstitute.org

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Multiple Facilities 3

Surgeon Name____

Surgical Facility No. 3:

Surgical Facility Name____

Delivery Address____

City______________________________ State__________ Zip______________

Phone______/____________ Ext________ Fax______/______________

Contact Name______________________________ Email:______________________

Cell:______/______________ PO Required? ☐ Yes ☐ No Delivery Hours________—________

Billing Address *(if different than Delivery)*________________________________

City______________________________ State__________ Zip______________

Surgical Facility No. 4:

Surgical Facility Name____

Delivery Address____

City______________________________ State__________ Zip______________

Phone______/____________ Ext________ Fax______/______________

Contact Name______________________________ Email:______________________

Cell:______/______________ PO Required? ☐ Yes ☐ No Delivery Hours________—________

Billing Address *(if different than Delivery)*________________________________

City______________________________ State__________ Zip______________

Surgical Facility No. 5:

Surgical Facility Name____

Delivery Address____

City______________________________ State__________ Zip______________

Phone______/____________ Ext________ Fax______/______________

Contact Name______________________________ Email:______________________

Cell:______/______________ PO Required? ☐ Yes ☐ No Delivery Hours________—________

Billing Address *(if different than Delivery)*________________________________

City______________________________ State__________ Zip______________

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